Department of Veterans Affairs
Office of Inspector General
February 2014 Highlights

ADMINISTRATIVE INVESTIGATION

Lax Supervision by VA Officials Leads to Misuse of Position, Travel, & Resources; Prohibited Personnel Practice Also Committed

The former (resigned) Director of VA's Center for Innovation did not properly detail and supervise a GS-12 Veterans Benefits Administration (VBA) Rating Veterans Service Representative (RVSR), which led to the RVSR misusing official time, taking unauthorized travel, misusing about $31,000 in travel funds, misusing a VA position and resources, and installing unapproved software to a VA laptop for sexting. The former Director also engaged in a prohibited personnel practice when he pressured VBA officials to create a non-competitive GS-13/14 position to give preference to and promote the RVSR; however, he intentionally did not tell the VBA officials of an ongoing Office of Inspector General (OIG) investigation of the RVSR for misconduct so that they could make fully informed decisions. Further, VBA officials engaged in a prohibited personnel practice when they failed to make proper considerations in their personnel decisions and created a position to promote the RVSR without question and solely due to the former Director's request. [Click here to access report.]

OIG REPORTS

Improvements Needed in Surgical Scheduling, Infection Control, Resident Supervision, and Quality Management at Columbia, South Carolina, VA Medical Center

OIG conducted a review in response to allegations concerning quality of care, clinical oversight, management controls, and administrative operations in the Surgery Service at the William Jennings Bryan Dorn VAMC (the facility) in Columbia, SC. OIG could not substantiate high general and vascular surgery complication rates or that contaminated surgical equipment contributed to surgical site infections. OIG substantiated improper use of hard-copy logbooks, insufficient staffing in surgery clinic, and several vacancies in Anesthesia Service. OIG did not substantiate patients being placed under extended anesthesia so residents could be trained in laparoscopic techniques, or that a power outage negatively impacted surgical patients. OIG determined that deficient surgical scheduling processes had a direct impact on operating room scheduling and caused case delays resulting in the use of overtime. The facility's Infection Control program was fragmented and inconsistent, surveillance data were rarely analyzed or trended, and Infection Control Sub-Council minutes lacked evidence of preventive and corrective measures. Also, Reusable Medical Equipment Oversight Committee minutes did not include required elements. OIG confirmed that the University affiliate had removed general and orthopedic surgery residents from the VA training rotation at different times; after some improvements, the general surgery residency program is again in jeopardy. The Quality Management program did not provide the necessary monitoring and oversight to assure that some patient care processes were safe and effective. High-level oversight and subordinate committees did not consistently receive required reports, act on identified conditions, or follow-up to resolution. The facility's Patient

Safety and Peer Review Programs did not comply with Veterans Health Administration (VHA) requirements, and many of the facility's key leaders were functioning in "acting" capacities. OIG made 12 recommendations. [Click here to access report.]

IG Recommends Improvements in Operating Room Cleanliness and Management of Infectious Patients at West Haven, Connecticut, Healthcare System

OIG conducted an inspection in response to allegations about deficiencies in the environment of care (EOC) in the operating room (OR) at the VA Connecticut Healthcare System (facility), West Haven, CT. OIG found that cleanliness of the OR could not be assured due to inadequate staff resources, incomplete and inconsistent procedures, poor supervision and training of Environmental Management Services (EMS) staff, and lack of oversight. OIG also found that safeguards were inadequate for ensuring patient and employee safety when infectious patients requiring special precautions were scheduled for OR procedures concurrently with noninfectious patients. OIG also identified issues related to maintenance of the Heating, Ventilation, and Air Conditioning (HVAC) system and insect control in the OR. Although OIG's findings substantiated an increased risk to patients and staff, OIG found no conclusive evidence that the EOC deficiencies in the OR resulted in negative patient outcomes. OIG recommended that the Facility Director strengthen procedures for OR cleaning and develop and implement policies and procedures to address management of infectious patients, the HVAC system preventive maintenance, and insect control in the OR. OIG also recommended that the Facility Director reassess EMS staffing needs in the OR, assign personnel requisite to the workload, and ensure that EMS staff and supervisors receive training on OR EOC requirements. Additionally, OIG recommended that the Facility Director implement procedures to monitor the OR EOC and to address identified deficiencies. [Click here to access report.]

Better Productivity Standards and Staffing Plans Will Improve Tracking, Repairs, and Timely Delivery of Hearing Aids to Veterans

OIG conducted this audit to evaluate the effectiveness of VA's administration of hearing aid order and repair services through VA's audiology services. Tinnitus and hearing loss were the first and second most prevalent service-connected disabilities for Veterans receiving compensation at the end of FY 2012. VA was not timely in issuing new hearing aids to Veterans or in meeting its 5-day timeliness goal to complete repair services. During the 6-month period ending September 2012, VHA issued 30 percent of its hearing aids to Veterans more than 30 days from the estimated receipt date from their vendors. Medical facilities' audiology staff attributed the delays to inadequate staffing to meet an increased workload. In addition, the Denver Acquisition and Logistics Center (DALC) took 17 to 24 days to complete hearing aid repair services, exceeding its 5-day timeliness goal. During this period, 5 of 21 repair technician positions were vacant. These vacancies, and an increased workload, adversely affected DALC's ability to meet its timeliness goal for hearing aid repairs. OIG observed and estimated about 19,500 sealed packages of hearing aids were waiting for repair and staff to record the date received into DALC's production system. According to management, staff did not record the date they received the packages because opening packages had the potential risk of losing small parts. Without a timely recording

system, staff cannot adequately respond to Veteran and medical facility inquiries. OIG recommended the Under Secretary for Health (USH) develop a plan to implement productivity standards and staffing plans for audiology clinics. Also, OIG recommended the Principal Executive Director of the Office of Acquisition, Logistics, and Construction (OALC) ensure DALC determines the appropriate staffing levels for its repair lab and establish controls to timely track and monitor hearing aids for repair. The USH and Principal Executive Director, OALC concurred with OIG's recommendations. [Click here to access report.]

Master Staffing Plan Needed for OR, Weaknesses Identified in the Surgical and OR Improvement Processes at Augusta, Maine, Healthcare System

OIG conducted an inspection to assess the merit of allegations concerning OR staffing, pre-operative anesthesia evaluations of complex patients, and the surgical mortality rate at the VA Maine Healthcare System (HCS), Augusta, ME. OIG substantiated that the OR did not have a front desk clerk and/or a nurse scheduled to work in the clean core area. However, due to the absence of a master staffing plan, OIG could not substantiate that the current staff was inadequate to support OR staff. OIG did not substantiate that pre-operative anesthesia evaluations of complex patients are inadequate because providers frequently evaluate patients just prior to surgery. OIG's review of the surgical mortality data did not identify obvious outliers or negative trends that would indicate systemic quality of care issues in the OR and require further review. In addition to the allegations, OIG identified weaknesses in the surgical and OR quality improvement processes. OIG recommended that the VA Maine HCS Director develop and implement a master staffing plan for the OR, ensure that the Surgical Work Group and OR Committee are functioning in accordance with VHA and local policies, and that the recommendations made pursuant to a recent protected VHA Surgical Program review are implemented. [Click here to access report.]

Issues with Pressure Ulcer Prevention, Communications with Family Found at Augusta, Georgia, VA Medical Center

OIG conducted an inspection at the Charlie Norwood VA Medical Center (VAMC) in Augusta, GA, in response to allegations received through OIG's Hotline Division and from Congressman Doug Collins' office concerning poor patient care, lapses in communication between facility staff and the patient's family, inadequate physician/nurse staffing, loss of the patient's personal property, and failure to provide medical information to another facility. OIG substantiated that the patient developed pressure ulcers on his sacrum and coccyx after admission to the hospital and that documentation of care rendered to prevent ulcers was inconsistent. Since the facility is in the process of improving the prevention of pressure ulcer program and progress will be monitored through the Combined Assessment Program (CAP) review follow-up, OIG made no recommendations concerning this allegation. OIG substantiated that facility staff and physicians failed to effectively communicate with the patient's family regarding the patient's condition and treatment needs. OIG substantiated that facility staff did not securely safeguard the patient's personal belongings during the patient's hospitalization. OIG did not substantiate the allegation that staff members expressed concern regarding inadequate nurse staffing levels. OIG found that nurse staffing levels in the intensive

care unit met or exceeded target levels. OIG addressed the physician staffing levels in the context of resident physician communications with the family. OIG did not substantiate the allegation that the facility did not provide the private rehabilitation center with current patient health records. OIG recommended that the Facility Director (1) ensure that patient information is shared with patients, families, and significant others in an appropriate manner that protects patient privacy and (2) ensure that processes be strengthened for inventory, documentation, storage, and retrieval of patient belongings, and that compliance is monitored. [Click here to access report.]

Combined Assessment Program Reviews

In February 2014, the Office of Healthcare Inspections published five CAP reviews containing OIG findings for the medical centers and health care systems listed below. The purpose of the CAP reviews was to evaluate selected health care facility operations and to provide crime awareness briefings. Topics reviewed may vary due to differences in services provided at each facility, the need to follow up on previous CAP findings, or the rotation of CAP review topics over time.

Lexington VAMC, Lexington, Kentucky
VA Central Iowa HCS, Des Moines, Iowa
James E. Van Zandt VAMC, Altoona, Pennsylvania
Louis Stokes Cleveland VAMC, Cleveland, Ohio
Topics reviewed:

- Quality management (QM)
- EOC
- Medication management (MM)
- Coordination of care
- Nurse staffing
- Pressure ulcer prevention and management
- Community Living Center resident independence and dignity

White River Junction VAMC, White River Junction, Vermont
VA Salt Lake City HCS, Salt Lake City, Utah
Topics reviewed:

- QM
- EOC
- MM
- Coordination of care
- Nurse staffing
- Pressure ulcer prevention and management

Southeast Louisiana Veterans HCS, New Orleans, Louisiana
Topics reviewed:

- QM
- EOC
- MM

- Women's health
- Continuity of care
- Management of workplace violence

Boise VAMC, Boise, Idaho
Topics reviewed:

- QM
- MM
- Coordination of care
- Nurse staffing
- Pressure ulcer prevention and management
- Community Living Center resident independence and dignity

Community Based Outpatient Clinic Reviews
In February 2014, the Office of Healthcare Inspections published five Community Based Outpatient Clinic (CBOC) reviews containing OIG's findings at select CBOCs and primary care clinics that fall under the oversight of the parent facilities listed below. The purpose of the CBOC reviews was to evaluate four operational activities: (1) EOC, (2) alcohol use disorder, (3) MM, and (4) designated women's health provider.

- Southeast Louisiana Veterans HCS, New Orleans, Louisiana
- VA Montana HCS, Fort Harrison, Montana
- Orlando VAMC, Orlando, Florida
- Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri
- VA Salt Lake City HCS, Salt Lake City, Utah

Another CBOC review was conducted in February 2014 to evaluate three operational activities: (1) alcohol use disorder, (2) MM, and (3) designated women's health provider.

- Boise VAMC, Boise, Idaho

CRIMINAL INVESTIGATIONS
Former VAMC Director Pleads Guilty to Corruption
The former Director of the Cleveland, OH, VAMC and the Dayton, OH, VAMC pled guilty to 64 corruption-related charges. The plea agreement also requires the defendant to pay more than $400,000 in restitution, forfeiture, and fines. A 2-year OIG and Federal Bureau of Investigation (FBI) investigation revealed that the defendant engaged in money laundering, fraud, and conspiracy to defraud VA by accepting thousands of dollars from contractors in exchange for inside information. As part of the scheme, the defendant conspired with employees of a company to defraud VA by providing confidential information about VA contracts and projects the company was seeking to obtain, causing a potential loss to the Government of approximately $20 million.

Former Palo Alto, California, VAMC Employee Pleads Guilty to Bribery
A former Palo Alto, CA, VAMC employee pled guilty to bribery. An OIG and FBI investigation revealed that the defendant, who was a Contracting Officer's

Representative, accepted bribes to include cash, airplane tickets for personal travel, and payments for his personal credit card bills in exchange for his influence in getting work for VA contractors. The defendant also provided contractors with confidential pricing information on various construction projects and used his influence to promise continued work to the contractors. The investigation determined that the defendant received $16,527 in bribes and gifts.

Former Lexington, Kentucky, VA Police Lieutenant Sentenced for Theft of Weapons

A former Lexington, KY, VA Police Service lieutenant was sentenced to time served, 36 months' probation, and ordered to pay $765 in restitution. An OIG investigation revealed that the defendant, a police armorer, was allowed unescorted access to the VA Police armory. Subsequently, the defendant stole four Beretta 9mm semi-automatic handguns. The defendant then pawned the handguns for cash throughout the local community. OIG and the VA Police Service were able to recover the stolen weapons.

Former Jackson, Mississippi, VAMC X-Ray Technician Arrested for Theft of Computer

A former Jackson, MS, VAMC x-ray technician was indicted and subsequently arrested for the theft of a VA computer from an examination room at the medical center. The laptop was recovered at a junior college by OIG and the campus police.

Miami, Florida, VAMC Police Officer Sentenced for Extortion

A Miami, FL, VAMC police officer was sentenced to 2 months' incarceration, 1 year of supervised release, and ordered to pay a $300 special assessment fee. An OIG investigation revealed that the officer used his position to access a State law enforcement database to obtain personal information regarding a U.S. Army service member. The officer then extorted the service member by threatening to post sexually explicit images and provide embarrassing information on social media if the victim failed to pay additional money on a previously satisfied personal loan. The defendant used VA networks and computers to send the extortion emails to the victim. Also, while off-duty and not in any official capacity, the defendant conducted a traffic stop of an off-duty local police officer, using his personally owned vehicle which was equipped with emergency lights, siren, and radio.

Former Nashville, Tennessee, VAMC Supervisory Pharmacist Arrested for Theft

A former Nashville, TN, VAMC supervisory pharmacist was indicted and arrested for theft and official misconduct. An OIG investigation revealed that the defendant diverted large amounts of drugs from the medical center where she was employed as the night shift supervisor.

VA Contract Employee Pleads Guilty to Theft

A certified nursing assistant providing contract services to the Philadelphia, PA, VAMC pled guilty to theft of Government funds. An OIG investigation revealed that the defendant filed fraudulent time sheets with her employer who then billed VA for payment. The defendant claimed to work an average of 100 hours per week during a

period when no actual work was performed. The defendant's employer assisted during the investigation and reimbursed VA $78,819 following the defendant's plea.

Veteran Indicted for Assault of Two Bath, New York, VAMC Police Officers
A Veteran was indicted for assault after an OIG and VA Police Service investigation revealed that he assaulted two VA police officers while at the Bath, NY, VAMC. At the time of the assault, the defendant was being processed for possible admission. The Veteran is being held pending further judicial action.

Veteran Arrested for Assault of East Orange, New Jersey, VAMC Employee
A Veteran was arrested for assaulting an East Orange, NJ, VAMC employee. An OIG investigation revealed that the defendant attacked a social worker by spitting in her face and fracturing her elbow. The defendant was held pending a bail hearing.

Veteran Sentenced for Making Bomb Threat to Detroit, Michigan, VA Regional Office
A Veteran was sentenced to 8 months' incarceration and 2 years' probation after pleading guilty to making a false bomb threat. An OIG and sheriff's office investigation revealed that the Veteran called the VA Crisis Hotline and said he had 4 pounds of C4 explosives and ball bearings and that he was going to the Detroit, MI, VA Regional Office for payback after being denied benefits.

Three Defendants Sentenced for Wire Fraud
Three defendants were sentenced after pleading guilty to wire fraud. The first defendant was sentenced to 2 years' incarceration and 3 years' supervised release. The second defendant was sentenced to 5 years' probation, and the third defendant was sentenced to 2 years' incarceration and 3 years' supervised release. All three defendants were ordered to pay VA a total of $147,285 in restitution. An OIG investigation revealed that these defendants and three others were involved in rigging bids to refurbish VA-acquired properties. The other defendants were previously sentenced.

Defendant Charged with Theft of VA Property
A defendant was charged in a criminal information with theft of Government property and with introducing into interstate commerce a stolen device that was misbranded. An OIG and Food and Drug Administration investigation revealed that the defendant stole eight Olympus endoscopy and colonoscopy scopes from VAMCs in Dayton, OH, and Fort Wayne, IN. The defendant also admitted to the theft of scopes from other public and private hospitals. The loss to VA is approximately $220,000.

Former Tampa, Florida, VAMC Volunteer Pleads Guilty to Identity Theft
A former volunteer at the Tampa, FL, VAMC pled guilty to conspiracy to defraud the Government, access device fraud, and aggravated identity theft. An OIG, Internal Revenue Service (IRS) Criminal Investigation Division (CID), and local police investigation revealed that the defendant stole VA patients' Personally Identifiable

Information (PII), traded it for crack cocaine, and used the PII to file $522,981 in fraudulent tax returns.

Veteran Sentenced for Identity Theft
A Veteran was sentenced to 30 months' incarceration, 36 months' supervised release, and ordered to pay VA $178,607 in restitution. An OIG investigation revealed that for over 7 years the defendant, a wanted fugitive felon, used the identity of his brother and fraudulently received approximately $178,000 in VA health care benefits and pension benefits. The defendant's brother resides in the Netherlands and never applied for or received any VA benefits. During the investigation, evidence was secured by the State Department through the Dutch National Police that was critical to the defendant's conviction.

Veteran Pleads Guilty to Identity Theft and Fraud
A Veteran pled guilty to aggravated identity theft, wire fraud, and bank fraud. A VA OIG, Social Security Administration (SSA) OIG, Treasury OIG, and Washington State Social and Health Services investigation revealed that the defendant stole the personal identification of two Veterans to establish fraudulent VA e-Benefit accounts and re-route compensation payments to prepaid debit cards. The defendant obtained information on over 100 individuals and caused a combined loss of over $85,000 to VA, SSA, private individuals, and corporations.

Non-Veterans Convicted of Using Veterans' Identity for Tax Refund Fraud
A non-Veteran was found guilty at trial of wire fraud, theft of Government funds, and aggravated identity theft. An OIG, IRS CID, and Florida Highway Patrol investigation revealed that the defendant used Veterans' PII from stolen VA medical records and other information to file $630,783 in fraudulent tax returns. In a separate case, two other non-Veterans pled guilty to access device fraud and aggravated identity theft. An OIG, IRS CID, and local police investigation revealed that the defendants used Veterans' PII obtained from stolen Tampa, FL, VAMC medical records to file $469,391 in fraudulent tax returns.

Veteran Indicted for Theft of VA Education Benefits
A Veteran was indicted for theft of Government funds after an OIG investigation revealed that he falsely claimed to be attending school at a community college. The defendant made these fraudulent claims in order to obtain Post 9/11 GI Bill benefits and carried out his scheme by obtaining and submitting VBA documentation used by schools to certify enrollment. The loss to VA is approximately $70,000.

Veteran Indicted for Health Care Fraud
A Veteran was indicted for health care fraud and false statements relating to health care matters. An OIG investigation revealed that the defendant misrepresented the extent and severity of his disabilities. Specifically, the Veteran claimed, and was rated for, the loss of use of both of his feet. In actuality, the defendant is capable of walking unassisted. The loss to VA is approximately $260,000.

Veteran Sentenced for Making False Statements to VA
A Veteran was sentenced to 60 months' probation, 180 days' home detention, and ordered to pay VA $63,562 in restitution after pleading guilty to making false statements. An OIG investigation revealed that between August 2007 and July 2011 the defendant failed to report his earnings in order to fraudulently receive VA pension benefits.

Veteran Pleads Guilty to Theft of Government Travel Benefits
A Veteran pled guilty to theft of Government funds after an OIG investigation revealed that for over 5 years the defendant filed more than 450 fraudulent travel vouchers with the Tuscaloosa, AL, VAMC. The defendant claimed to be traveling from Mississippi when he actually resided in Tuscaloosa. The loss to VA is $42,750.

Niece of Deceased Beneficiary Pleads Guilty to Theft of Public Money
The niece of a deceased beneficiary pled guilty to theft of public money. After her aunt's death in April 2005, the defendant transferred VA funds from her deceased aunt's account into another account in her aunt's name. The defendant then withdrew the funds and used them to pay her expenses. The loss to VA is $105,765.

Friend of Deceased VA Widow Beneficiary Sentenced for Theft of Government Funds
The friend of a deceased VA widow beneficiary was sentenced to 2 years' probation and ordered to pay restitution of $130,071 after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after the beneficiary's death in April 2003.

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Acting Inspector General